Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNIVERSAL DME

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-15-0910-02

Carrier's Austin Representative
Box Number 45

MFDR Date Received
November 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed for an E0217 RR at 7 units totaling $528.85. Our claim was processed with a payment of $17.63. Texas Workers Compensation claims are to be reimbursed 125% of the Medicare allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 3rd quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%. Attached is a copy of the CGS Fee Schedule for the E0217, 3rd quarter 2014. We are owed a balance of $511.22."

Amount in Dispute: $511.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a review of the medical billing received from Universal DME, which found that an erroneous audit had been performed. The Office has requested an immediate re-audit of the services in dispute to allow reimbursement pursuant to the aforementioned agreement to include interest if applicable."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2014 through August 25, 2014	E0217-RR x 7 units	$511.22	$0.00

AMENDED FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decision rendered in the medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 193 – Original payment decision is being maintained
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
   - W3 – Additional payment made on appeal/reconsideration

Issues

Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.203 (b) states in pertinent part, “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;… and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.” Furthermore, 28 Texas Administrative Code §134.203(a)(1)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

The service in dispute is durable medical equipment that was billed with HCPCS Level II code E0217 “Water circulating heat pad with pump.” The *Medicare Claims Processing Manual 100-04, Chapter 20,* found at www.cms.gov sets out the Medicare payment polices applicable to DME. Section 30 sets out the general payment rules including payment categories for durable medical equipment. The category and fee schedule amount for E0217 may be found in the DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) fee schedule at www.cgsmedicare.com. E0217 is categorized as “Inexpensive/Routinely Purchased” DME. Section 30.1 titled *Inexpensive or Other Routinely Purchased DME* states “For this type of equipment, contractors pay for rentals or lump-sum purchases. However, with the exception of TENS (see 30.1.2), the total payment amount may not exceed the actual charge or the fee schedule amount for purchase.” The division must therefore establish both the fee schedule amount, and the requestors purchase price for E0217 in order to apply Medicare payment policy as required by 28 Texas Administrative Code §134.203(b).

Applicable 28 Texas Administrative Code §134.203(d) states “The MAR [maximum allowable reimbursement] for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.” As stated above the applicable Medicare payment policy requires the division to compare the fee schedule amount and the purchase price to arrive at the Medicare fee. The requestor has the burden to support its purchase price for the service in dispute for the purpose of making the initial comparison. No documentation was found to support the requestor’s purchase price for E0217. Consequently, the division is unable to make the comparison between that is required to arrive at the appropriate Medicare fee needed to calculate the Texas workers’ compensation MAR at §134.203(d)(1). For that reason, the division finds that the requestor has failed to sufficiently support its request for additional reimbursement.

Conclusion

The Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services. Even though all the evidence was not discussed, it was considered.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 26, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.